Senior Intake Form 60 + yrs

Dr. Anna Martin, ND
Functional Medicine Doctor

Powered by Rebound SportsMed

Patient's Name:_______________________________________ Date: ____________

Age:____ Date of Birth:____/____/________ female male

Mother's name:______________________ Father's name ________________________

Address:__________________________City:______________ State:_____ Zip ______

Home Phone (_____)__________________ Work Phone (_____)________ ___________

Occupation (past and/or present)______________________Part or Full Time or Retired

Soc. Sec. #_________________________ Education: ____________________________

☐Married ☐Separated ☐Divorced ☐Widowed ☐Single ☐Cohabitating

Live with: ☐Spouse ☐Partner ☐Relatives ☐Children
☐Friends ☐Parents ☐Alone

Next of Kin or other to reach in case of emergency_______________ Relationship _____

Address ___________________Phone______________ Work Phone ________________

Name of Family Doctor:_______________________ Phone ____________________

Insurance

Name policy is in: _______________________ Health insurance: Company:___________

Policy/I.D. No.:__________________________ Group/code No.: ____________________

A NOTE TO OUR PATIENTS: Naturopathic, hollistic, and preventive health care require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take the time to complete this health history questionnaire carefully and thoroughly.

Current Health Condition

When, where and from whom did you last receive medical or health care? _____________________

Reason? ____

How did you hear about this clinic: ____

List of most important health problems, in order of importance:

1) ____
2) ____
3) ____
4) ____

Which of the above problems are of most immediate concern? ___________________________

Do you have any contagious diseases at this time: Yes No
If yes, what? ____

Family History

If any blood relative had any of the following, please indicate their relationship to you (see key below) and name the disease on the line provided, following each condition:

F=father **M**=mother **GF**=grandfather **GM**=grandmother
S=sister **B**=brother **A**=aunt **U**=uncle **O**=offspring

Genetic Disease ________	Bleeding easily __________	Anemia ____________
Allergies/Hayfever________	Asthma ________________	Eczema ____________
ArthritisIRheumatism______	Cancer/Tumor____________	Diabete____________
High blood pressure ______	Heart Disease____________	Stroke_____________
Kidney disease __________	Thyroid trouble __________	Diabetes____________
Stom/Duod ulcer ________	Tuberculosis ____________	Glaucoma___________
Mental illness __________	Epilepsy ________________	Dementia ___________
Alcohol addiction________	Drug addiction __________	Other _____________

Childhood Illnesses:

☐Scarlet fever ☐Diptheria ☐Rheumatic fever ☐Mumps
☐Measles ☐German measles ☐Other____________________

Immunizations:

☐Polio ☐Pertussis ☐Diptheria ☐Tetanus shot ☐Measles/Mumps/Rubella
☐Influenza ☐Pnuemococcal ☐TB staus ☐Other______________________________

Hospitalizations and/or Surgeries: (include reason/diagnosis and dates)

1)________________________________ 4)________________________________
2)________________________________ 5)________________________________
3)________________________________ 6)________________________________

X-rays and Special studies: (include reasons and dates)

X-rays____
CAT scan ____
MRI Electrocardiogram_____________________________________
Electroencephalogram _____________________________________
Other ____

Allergies: (list any foods, drugs, or other allergens)

____
____

Current Medications: (include name, dosage, and frequency of use)

Prescription drugs

1)________________________________ 5)________________________________
2)________________________________ 6)________________________________
3)________________________________ 7)________________________________
4)________________________________ 8)________________________________

Over-the-counter drugs: including supplements

1)________________________________ 5)________________________________
2)________________________________ 6)________________________________
3)________________________________ 7)________________________________
4)________________________________ 8)________________________________

Others:_____________________________

Social Assessment:

1) Has any of the following happened in the last year? (describe if yes)

☐ Death of spouse ____________________

☐ Death of other close family member of friend ____________________

☐ Change in health of family member____________________

☐ Change in living situation Divorce or separated Marriage or “pairing up” ____________________

☐ Change in financial status ____________________

2) For each of the following questions, which description comes closest to the way you have been feeling during the past month?

	All the time	Most of the time	Some of the time	A little of the time	None of the time
a. How much of the time, during the past month, have you been a very nervous person?	☐	☐	☐	☐	☐
b. During the past month, how much of the time have you felt calm and peaceful?	☐	☐	☐	☐	☐
c. How much of the time, during the past month, have you felt downhearted and blue?	☐	☐	☐	☐	☐
d. During the past month, how much of the time have you been a happy person?	☐	☐	☐	☐	☐
e. During the past month, have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
f. During the past month, how ofte did you feel like life isn’t worth living?	☐	☐	☐	☐	☐

3) How often do visitors come to see you? ☐Daily ☐Weekly ☐Less often ☐Never

4) Describe what you ate yesterday (or on any typical day):

Breakfast____________________

Lunch ____________________

Dinner ____________________

Snack/Drinks____________________

Functional Status:

1) For how long (if at all) has your health limited you in each of the following activities?

	Limited for more than 3 months	Limited for less than 3 months	Not limited at all
a. The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running, participating in strenuous sports, etc.	☐	☐	☐
b. Working at a job	☐	☐	☐
c. Walking uphill of climbing stairs	☐	☐	☐
d. Bending, lifting, or stooping	☐	☐	☐
e. Walking one block	☐	☐	☐
f. Eating, dressing, bathing, or using the toilet	☐	☐	☐

2) Do you require help for any of the following? If yes, who provides it?

Meal preparation____

Shopping ____

Light housekeeping Laundry ____

Getting out of bed Getting into bed Dressing ____

Bathing ____

Review of Symptoms

Please circle one, only if it applies to you: and briefly describe, if possible

C=chronic condition, **N**=new, **P**=Past.

General

Weight________ Weight 1 year ago_______ Maximum weight________ When_____Height_________

Skin

- Rashes.......C N P
- Eczema, hives.......C N P
- Lesions.......C N P
- Itching.......C N P
- Color change.......C N P
- Lumps.......C N P
- Night sweats.......C N P
- Excessive dryness.......C N P

Head

- Headache.......C N P
- Head injury.......C N P

Eyes

- Impaired vision.......C N P
- Eye pain.......C N P
- Tearing or dryness.......C N P
- Double vision.......C N P
- Glaucoma.......C N P
- Cataracts.......C N P

Ears

- Impaired hearing.......C N P
- Ringing.......C N P
- Earache.......C N P
- Dizziness.......C N P
- Hearing aid.......C N P

Nose and Sinuses

- Frequent colds.......C N P
- Nose bleeds.......C N P
- Stuffiness.......C N P
- Hay fever.......C N P
- Sinus problems.......C N P

Mouth and Throat

- Frequent sore throat.......C N P
- Sore tongue.......C N P
- Gum problems.......C N P
- Hoarseness.......C N P
- Dental cavities.......C N P
- Dentures.......C N P
- Lesions.......C N P

Neck

- Lumps.......C N P
- Swollen glands.......C N P
- Goiter.......C N P
- Pain or stiffness.......C N P

Respiratory

- Asthma.......C N P
- Bronchitis.......C N P
- Pneumonia.......C N P
- Pleurisy.......C N P
- Emphysema.......C N P
- Difficulty breathing.......C N P
- Pain on breathing.......C N P
- Shortness of breath at night.C N P
- lying down.......C N P
- Tuberculosis.......C N P
- Cough.......C N P
- Sputum.......C N P
- Spitting up blood.......C N P
- Wheezing.......C N P

Cardiovascular

- Heart disease.......C N P
- Angina.......C N P
- High blood pressure.......C N P
- Murmurs.......C N P
- Rheumatic fever.......C N P
- Chest pain.......C N P
- Swelling in ankles.......C N P
- Palpitations, fluttering.......C N P

Gastrointestinal

- Trouble swallowing .... C N P
- Heartburn .... C N P
- Change in thirst .... C N P
- Change in appetite .... C N P
- Nausea .... C N P
- Vomiting .... C N P
- Vomiting blood .... C N P
- Loose stool .... C N P
- Constipation .... C N P
- Bowel movements .... C N P
- How often?______________
- Is this a change?_________
- Blood in stool .... C N P
- Belching/passing gas .... C N P
- Jaundice (yellow skin) .... C N P
- Liverdisease .... C N P
- Gall bladder disease .... C N P
- Ulcer .... C N P
- Hemorrhoids .... C N P
- Abdominal mass .... C N P

Urinary

- Pain on urination .... C N P
- Increased frequency .... C N P
- Frequency at night .... C N P
- Inability to hold urine .... C N P
- Involuntary urine leak .... C N P
- Bladder problems .... C N P
- Hesitancy/straining .... C N P
- Intermittent stream .... C N P
- Frequent infections .... C N P
- Kidney stones .... C N P

Female Reproductive

- Menstrual .... C N P
- Menopausal .... C N P
- Menopause symptoms .... C N P
- Vaginal bleeding .... C N P
- Hysterectomy .... C N P
- Reason? .... C N P
- Birth control? .... C N P
- What type? .... C N P
- Number of pregnancies? .... C N P
- Number of live births? .... C N P
- Number of miscarriages? .... C N P
- Number of abortions? .... C N P
- Sexually active? .... C N P
- Sexual difficulties .... C N P
- Venereal disease .... C N P
- Sexual preference: (circle one)
- Heterosexual Bisexual Homosexual

Breasts

- Do you self exam?
- Lumps/masses .... C N P
- Pain or tenderness .... C N P
- Nipple discharge .... C N P

Male Reproductive

- Hernias .... C N P
- Testicular masses .... C N P
- Testicular pain .... C N P
- Prostate disease .... C N P
- Venereal disease .... C N P
- Discharge or sores .... C N P
- Sexually active? .... C N P
- Sexual difficulties .... C N P
- Sexual preference: (circle one)
- Heterosexual Bisexual Homosexual

Multisystem

- Joint pain or stiffness .... C N P
- Joint swelling .... C N P
- Arthritis .... C N P
- Frequent dislocations .... C N P
- Broken bones .... C N P
- Muscle spasm/cramps .... C N P
- Weakness .... C N P
- Peripheral Vascular .... C N P
- Deep leg pain .... C N P
- Cold hands/feet .... C N P
- Varicose veins .... C N P
- Thrombophlebitis .... C N P
- Neurologic .... C N P
- Fainting .... C N P
- Seizures .... C N P
- Paralysis .... C N P
- Resting tremors .... C N P
- Muscle weakness .... C N P
- Numbness or tingling .... C N P
- Forgetfulness .... C N P
- Endocrine .... C N P
- Hypothyroid .... C N P
- Hyperthyroid .... C N P
- Heat/cold intolerance .... C N P
- Excessive thirst .... C N P
- Excessive hunger .... C N P
- Extremefatigue .... C N P
- Blood Anemia What type? .... C N P
- Easy bleeding/bruising .... C N P
- Blood disease .... C N P

Emotional

- Depression .... C N P
- Mood swings .... C N P
- Irritability .... C N P
- Anxiety/nervousness .... C N P
- Tension .... C N P
- Cries easily .... C N P
- Cries rarely .... C N P
- Other .... C N P
- Falls often .... C N P
- Unsteady sensations .... C N P

Habits:

What are your main hobbies and interests? List in order of preference, and amount of time spent on each:

1)________________________________ 3)________________________________
2)________________________________ 4)________________________________

Do you exercise? What forms and how often?

1)________________________________ 3)________________________________
2)________________________________ 4)________________________________

Other:

Do you eat 3 meals daily .... Y..... N
Awaken rested.................................. Y..... N
Sleep well .... Y..... N
Average 6-8 hours sleep .... Y..... N
Nap during day .... Y..... N
How often?______________
Insomnia .... Y..... N
Spend time outside........................... Y..... N
How often?________
Watch television .... Y..... N
How many hours a day?____________
Read .... Y..... N
How many hours a day?............................
Take vacations................................... Y..... N
How often?______________
Been treated for drug dependence.... Y..... N
Use reacreational drugs .... Y..... N
Use alcoholic beverages .... Y..... N
Been treated for alcoholism.............. Y..... N
Smoke or chew tobacco .... Y..... N

Extra Information:

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Thank you for your time and thoughtfulness in completing this intake form.